

NEW YORK STATE
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE		REGISTER NUMBER 5151 0314		1. NAME: FIRST MIDDLE LAST Jack Franqui IV		2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>		3A. DATE OF DEATH: MONTH DAY YEAR 01 23 2013		3B. HOUR Approx. 6:20 P			
NCHS		4A. PLACE OF DEATH: (Check one) HOSPITAL DOA <input type="checkbox"/> ER <input type="checkbox"/> HOSPITAL OUTPATIENT <input type="checkbox"/> HOSPITAL INPATIENT <input type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify): <input checked="" type="checkbox"/> Jail cell		4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR		4C. NAME OF FACILITY: (If not facility, give address) Suffolk County Police Dept. 7th Prct., Shirley		4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> Brookhaven		4E. COUNTY OF DEATH: Suffolk			
4C		4F. MEDICAL RECORD NO.		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO <input type="checkbox"/> YES <input type="checkbox"/>		5. DATE OF BIRTH: MONTH DAY YEAR 12 14 1986		6A. AGE IN YEARS: 26 yrs.		6B. IF UNDER 1 YEAR ENTER: months days			
4G		6C. IF UNDER 1 DAY ENTER: hours minutes		7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) West Islip, NY		7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:		8. SERVED IN U.S. ARMED FORCES? (Specify years) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A <input type="checkbox"/> No, not Spanish/Hispanic/Latino B <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano C <input checked="" type="checkbox"/> Yes, Puerto Rican D <input type="checkbox"/> Yes, Cuban E <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify)			
7A		10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be. A <input checked="" type="checkbox"/> White/Caucasian B <input type="checkbox"/> Black or African American C <input type="checkbox"/> Asian Indian D <input type="checkbox"/> Chinese E <input type="checkbox"/> Filipino F <input type="checkbox"/> Japanese G <input type="checkbox"/> Korean H <input type="checkbox"/> Vietnamese J <input type="checkbox"/> Native Hawaiian K <input type="checkbox"/> Guamanian or Chamorro M <input type="checkbox"/> Samoan N <input type="checkbox"/> American Indian or Alaska Native (specify) P <input type="checkbox"/> Other Asian (specify) S <input type="checkbox"/> Other (specify)		11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 <input type="checkbox"/> ≤ 8th grade 2 <input type="checkbox"/> 9th-12th grade, no diploma 3 <input checked="" type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate's degree 6 <input type="checkbox"/> Bachelor's degree 7 <input type="checkbox"/> Master's degree 8 <input type="checkbox"/> Doctorate/Professional degree		12. SOCIAL SECURITY NUMBER: 119-76-5371		13. MARITAL STATUS: NEVER MARRIED <input checked="" type="checkbox"/> 1 MARRIED <input type="checkbox"/> 2 WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/> 4 SEPARATED <input type="checkbox"/> 5		14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated.		15A. USUAL OCCUPATION: (Do not enter retired) Cook	
7B		15B. KIND OF BUSINESS OR INDUSTRY: Food		15C. NAME AND LOCALITY OF COMPANY OR FIRM: American Red Cross		16A. RESIDENCE: (State or Country if not USA) New York		16B. County or Region/Province if not USA: Suffolk		16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> Brookhaven			
SI		16D. STREET AND NUMBER OF RESIDENCE: 83 Magnolia Dr. Rocky Point		16E. ZIP CODE: 11778		16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SPECIFY TOWN.		17. BIRTH NAME OF FATHER / PARENT: FIRST MI LAST Joaquin Franqui		18. BIRTH NAME OF MOTHER / PARENT: FIRST MI LAST Phyllis Daily			
25		19A. NAME OF INFORMANT: Joaquin Franqui		19B. MAILING ADDRESS: (Include zip code) 83 Magnolia Dr. Rocky Point, NY 11778		20A. 1 <input type="checkbox"/> BURIAL 2 <input checked="" type="checkbox"/> CREMATION 3 <input type="checkbox"/> REMOVAL 4 <input type="checkbox"/> HOLD MONTH DAY 5 <input type="checkbox"/> DONATION YEAR 6 <input type="checkbox"/> ENTOMBMENT 01 28 2013		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Washington Memorial Park Mount Sinai, NY		20C. LOCATION: (City or town and state)			
30		21A. NAME AND ADDRESS OF FUNERAL HOME: Branch Funeral Home 551 Route 25 A Miller Place, NY 11764		21B. REGISTRATION NUMBER: 00208		22A. NAME OF FUNERAL DIRECTOR: John H. Vigliante		22B. SIGNATURE OF FUNERAL DIRECTOR: 		22C. REGISTRATION NUMBER: 13688			
31		23A. SIGNATURE OF REGISTRAR: 		23B. DATE FILED: MONTH DAY YEAR 01 28 2013		24A. BURIAL OR REMOVAL PERMIT ISSUED BY: 		24B. DATE ISSUED: MONTH DAY YEAR 01 27 2013		25. ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER			
31B		25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the cause stated Certifier's Name: Odette R. Hall, M.D. License No.: 243777 Signature:		25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Address: SUFFOLK COUNTY MEDICAL EXAMINER SUFFOLK COUNTY OFFICE BLDG. ROCKY POINT, NY 11778		25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:		26A. Attending physician attended deceased: FROM Month Day Year TO Month Day Year 26B. Deceased last seen alive by attending physician: Month Day Year 26C. Pronounced Dead ON 01 23 2013 AT 7:50 P M		27. MANNER OF DEATH: NATURAL CAUSE <input type="checkbox"/> 1 ACCIDENT <input type="checkbox"/> 2 HOMICIDE <input type="checkbox"/> 3 SUICIDE <input checked="" type="checkbox"/> 4 UNDETERMINED CIRCUMSTANCES <input type="checkbox"/> 5 PENDING INVESTIGATION <input type="checkbox"/> 6 28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES 29A. AUTOPSIES? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES 29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES			
OR		28. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) HANGING DUE TO OR AS A CONSEQUENCE OF: (B) DUE TO OR AS A CONSEQUENCE OF: (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):		30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) HANGING DUE TO OR AS A CONSEQUENCE OF: (B) DUE TO OR AS A CONSEQUENCE OF: (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):		31A. IF INJURY, DATE: MONTH DAY YEAR 01 23 2013		31B. INJURY LOCALITY: (City or town and county and state) Shirley, Suffolk, N.Y.		31C. DESCRIBE HOW INJURY OCCURRED: HANGED SELF		31D. PLACE OF INJURY: JAIL CELL	
OS		31E. INJURY AT WORK? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		33A. IF FEMALE: 0 <input type="checkbox"/> Not pregnant within last year 1 <input type="checkbox"/> Pregnant at time of death 2 <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death 3 <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death 4 <input type="checkbox"/> Unknown if pregnant within past year		33B. DATE OF DELIVERY: MONTH DAY YEAR		33C. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN			
QCOD		33D. DATE OF DEATH: MONTH DAY YEAR 01 23 2013		33E. TIME OF DEATH: AM PM 6:20 P		33F. NAME OF DECEASED: Jack Franqui		33G. DATE OF DEATH: MONTH DAY YEAR 01 23 2013		33H. TIME OF DEATH: AM PM 6:20 P			
CANCER		33I. DATE OF DEATH: MONTH DAY YEAR 01 23 2013		33J. TIME OF DEATH: AM PM 6:20 P		33K. NAME OF DECEASED: Jack Franqui		33L. DATE OF DEATH: MONTH DAY YEAR 01 23 2013		33M. TIME OF DEATH: AM PM 6:20 P			